



MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address:	MFDR Tracking #: M4-10-4400-01
PROVIDENCE MEMORIAL HOSPITAL C/O LAW OFFICE OF P MATTHEW O'NEIL 6514 MCNEIL DR BLDG 2 SUITE 201 AUSTIN TX 78729	DWC Claim #:
	Injured Employee:
Respondent Name and Box #:	Date of Injury:
TPCIGA FOR PHICO INSURANCE CO Box #: 50	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "TPCIGA ("the Carrier") has failed to pay claim per Beech Street Coventry preferred provider agreement, which requires payment of 55% of Hospital's charges. Total charges for claim were \$57,382.28, with a proper contractual allowable of \$31,560.25. To date, only \$22,865.25 has been paid. Thus, claim was underpaid in the amount of \$8,695.00."

Amount in Dispute: \$8,695.00

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This letter is in response to the final demand for payment letter our client (TPCIGA) received from your office. We have reviewed the charges and determined that an additional amount of \$3751.11 is due. Attached is a sample explanation of benefits that shows how the charges should have originally been reimbursed according to the Texas Workers' Compensation Outpatient Hospital Fee Schedule. This amount is \$26,616.36. Based on the information from Coventry, your PPO contract only applies to billed charges and for those services it is 55% of the billed amount... An amount of \$22,865.25 has been reimbursed previously. Therefore, deducting this amount from the fee schedule amount of \$26,616.36, there is an additional \$3751.11 due. This amount has been issued by TPCIGA. "

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
06/17/2009	Hospital Outpatient Services	$\$11,424.60 \times 200\% = \$22,849.20 + 39.81 \text{ (fee schedule)} =$ $\$22,889.01 - \$26,616.36$	\$8,695.00	\$0.00
			Total Due:	\$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division rule at 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, effective for medical services provided in an outpatient acute care hospital on or after March 1, 2008, set out the reimbursement guidelines for hospital outpatient services.

This request for medical fee dispute resolution was received by the Division on June 16, 2010.

According to the explanation of benefits, the services in dispute were paid using a contracted fee arrangement. Tex. Lab. Code Ann. §413.011(d-3) states that the division may request copies of each contract under which fees are being paid, and goes on to state that the insurance carrier may be required to pay fees in accordance with the division's fee guidelines if the contract is not provided in a timely manner to the division. On September 30, 2010 the division requested a copy of the

contract between the network and the health care provider. The carrier responded on October 15, 2010 stating that after careful review, it was determined that a network reduction should not have been applied and that for date of service 06/17/2009, Providence Memorial Hospital was not participating in the FOCUS network.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason code:
 - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
 - 881 – This item is an integral part of an emergency room visit or surgical procedure and is therefore included in the reimbursement for the facility/APC rate.
 - 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
 - P32 – A First Health/FOCUS/Beech Street PPO contract discount was applied.
 - 785 – Items and/or services are packaged into APC rate. Therefore there is no separate APC payment.
 - 222 – Charge exceeds fee schedule allowance.
 - W1 – Workers Compensation State Fee Schedule adjustment.
 - Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
 - W3 – Additional payment made on appeal/reconsideration.
2. Division rule at 28 TAC §134.403(e) states, in pertinent part, that “Regardless of billed amount, reimbursement shall be:
 - (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code 413.011; or
 - (2) if no contracted fee schedule exists that complies with Labor Code 413.011, the maximum allowable reimbursement (MAR) amount under subsection (f), including any applicable outlier payment amounts and reimbursement for implantables;”
3. Pursuant to Division rule at 28 TAC §134.403(f), “The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the *Federal Register*. The following minimal modifications shall be applied.
 - (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
 - (A) 200 percent; unless
 - (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent.”
4. Under the Medicare Outpatient Prospective Payment System (OPPS), all services are classified into groups called Ambulatory Payment Classifications (APCs). Services in each APC are clinically similar and require similar resources. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Within each APC, payment for ancillary and supportive items and services is packaged into payment for the primary independent service. Packaged services are considered integral to the primary paid service and are not separately reimbursed. An OPPS payment status indicator is assigned to each HCPCS code. The status indicator for each HCPCS code is shown in OPPS Addendum B, and a full list of status indicators and their definitions is published in Addendum D1 of the OPPS proposed and final rules each year, both of which are publicly available from the Centers for Medicare and Medicaid services.
5. Upon review of the documentation submitted by the Requestor and Respondent, the Division finds that:
 - (1) No documentation was found to support a contractual agreement between the parties to this dispute;
 - (2) MAR can be established for these services; and
 - (3) Separate reimbursement for implantables was NOT requested by the requestor.
6. Consequently, reimbursement will be calculated in accordance with Division rule at 28 TAC §134.403(f)(1)(A) as follows:

APC	Outlier Amount	Separate reimbursement for implantables WAS NOT requested under Rule §134.403	APC X 200%	Fee Schedule (CMS x DWC conversion factor)	Less amount paid by Respondent	Additional amount due Requestor
\$11,424.60	\$0.00	\$0.00	\$22,849.20	\$39.81	\$26,616.36	\$0.00

Based upon the documentation submitted by the parties and in accordance with Texas Labor Code §413.031(c), the Division concludes that the requestor is not due additional payment. As a result, the amount ordered is \$0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code §413.011(a-d), §413.031 and §413.0311
28 Texas Administrative Code §133.305, §133.307, §134.203, §134.403
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is not entitled to additional reimbursement for the services involved in this dispute.

DECISION:

Authorized Signature

Medical Fee Dispute Resolution Officer

March 14, 2011
Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 TAC §148.3(c).

Under Texas Labor Code §413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.